## State of New Jersey — Department of the Treasury Division of Pensions and Benefits • PO Box 295 • Trenton, NJ 08625-0295 • (609) 292-7524

## APPLICATION FOR DISABILITY RETIREMENT STATE POLICE RETIREMENT SYSTEM (SPRS)

Please Read Instructions Prior to Completing Application

## PART ONE: MEMBER INFORMATION

1.	1. Membership Number 2. SSN _							
3.	3. Name 4. Date o	f Birth						
5.	Last, First, MI 5. Home Mailing Address	Month, Day, Year						
	Street Address, City, State, Zip Co	de						
6.	6. Phone #s — Home () Work (_	)						
7.	7. Current Work Title							
8.	8. Type of Disability Retirement ORDINARY ACCIDENTAL							
9.	I declare that I am incapacitated for further service in the work title listed in Item 7 due to the following reasons:							
10.	10. Retirement Effective Date — The first day of (month/year)							
11.	11. If you will have an outstanding loan balance at retirement, how do you wan	f you will have an outstanding loan balance at retirement, how do you want to pay the loan off?						
	Continue Payments into Retirement Lump Sum							
12.	12. Are you currently under departmental charges or formal indictment?	O YES						
(Qı	(Questions #13 and #14 are for Accidental Disability only.)							
13.	13. Date of Accident Descri	be the accident and list any witnesses to it.						
14.	Has a claim been filed for Workers' Compensation? NO YES							
	a) Amount of Periodic Benefit \$per week.							
	b) Beginning date of award c) Ending d	ate of award						

Official Title

PAI	RTTWO: MARI	TAL STATUS	AND CHILDREN					
15.	Marital Status	Single	Married	Widowed	Separated		Divorced	
16.	Name of Spouse					_ (		)
		Last	First	MI			(Maide	n Name)
17.	Spouse's SSN_							
18.	Spouse's Mailing	Address (if diffe	rent from member's	s)				
	S	Street Address			City		State	Zip Code
19.	Children: List an (see instructions		dren under 18 year: <i>children)</i> .	s of age. Be sure	e to indicate both t	he gend	er and birth d	late of each child
	Name							
		Last		First		MI	Gender	Date of Birth
	Name	Last		First		MI	Gender	Date of Birth
	Name							
		Last		First		MI	Gender	Date of Birth
PAI	RT THREE: DE	SIGNATION O	F GROUP LIFE	INSURANCE	BENEFICIARY			
20.	Primary Beneficia	ary(ies)						
	Full	Name	Address			Date of	Birth	Relationship
	Full	Name	Address			Date of	Birth	Relationship
	Full	Name	Address	;		Date of	Birth	Relationship
21.	Contingent Benef	iciary(ies)						
	Full	Name	Address			Date of	Birth	Relationship
	Full	Name	Address			Date of	Birth	Relationship
	Full	Name	Address			Date of	Birth	Relationship
	mber's					r	Noto	
Sigi	nature	(You	r signature must b	e notarized)		L	Jale	
Sta	te of		_, County of					
Swo	orn and subscribe	ed before me this	day of _					
	Commission expi		·	Month	Year			
Sigı	nature of Notary F	Public	Month		Year			